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ABSTRACT

In the recent past, there has been a great deal of effort directed toward developing techniques for documenting therapeutic outcome. Funding sources and the general public seem to be demanding more meaningful data which indicate, in a clear manner, whether or not the services they are paying for are of value. Mental health centers, like other human service providers, are very much involved in this endeavor. This paper describes an evaluation system developed at the Weber Mental Health Center in Ogden, Utah. The system is a simple checklist containing both an Evaluation Summary (to be filled out by the intake worker) and a Treatment Plan. It has the advantage of being simple, short, and clear-cut. The paper concludes by suggesting directions for future refinements and applications of the evaluation system. (Author/BP)

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MEASURING THERAPEUTIC EFFECTIVENESS

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MEASURING THERAPEUTIC EFFECTIVENESS

In the recent past, there has been a great deal of effort directed toward developing techniques for documenting therapeutic outcome. Funding sources and the general public seem to be demanding more meaningful data which indicate, in a clear manner, whether or not the services they are paying for are of value. Mental health centers, like other human service providers, are very much involved in this endeavor. This paper describes an evaluation system developed at the Weber Mental Health Center in Ogden, Utah.

It was the desire of those concerned in our Center, to develop a system that would reflect changes in "real" problems of people who commonly come to our Center to seek assistance. As a major beginning point the clinical director Dr. C. W. Dalley, developed a list of problem categories designed to encompass the needs that people came to the Center for help with. These categories were included in a one page intake form along with minimal personal data (see attached form). At first an intake worker would then merely check each of the problem catergories which was significant to the client as he came in for services. These checked problem catergories became the basis for developing a goal or set of goals for a therapeutic intervention by the caseworker assigned. This problem check method was used for approximately a year and during that period of time there were many revisions of the form, particularly in the refinement of the problem catergories. An evaluation committee at the Center composed of the clinical director, psychologist, social workers and a mental health board member who is also a professor of psychology, worked on the refinement of the form and procedure. In addition, as each new revision was made Center therapists were involved in discussion of the practicality and usefulness of the catergories and procedures. The checking of problem catergories at intake was useful in setting up treatment plans and checking status at termination. Progress notes reflected subjective improvement

or elimination of problems entirely. It was decided, however, that a more accurate and detailed measure would be desirable. The next step was to develop a measure of intensity of various kinds of problems. Rating of intensity of specified problems necessitated common definitions in each problem catergory. To accomplish this the committee first developed a five point scale of problem severity in each of the catergories listed on the form. This was followed up by again trying out the various catergory definitions in practical usage by therapists and intake staff. Several of the definitions were reworked until all were adopted as final rating descriptions. Once the definitions for each catergory were finalized it was possible to rate problem severity rather than just using a check mark. Intake staff was then able to more objectively pinpoint the major problems and the extent to which they were exhibited at intake. The same procedure could be accomplished at various intervals, particularly at termination, and to get a numerical difference reflecting the change resulting from the therapeutic interventions designed to assist the client.

An important feature in this system is the joint rating of problem severity by the client and mental health staff person responsible. There are but few cases where the staff person at intake has to decide the extent of the problem without a good deal of input from the client. An example of this might be a severely psychotic person who may not be able to rationally agree upon the severity of his problem.

Another important positive feature of the system is that specific problems rated at intake are handled by assigned therapists in specific kinds of programs. Program effectiveness can readily be related and compared for each of the programs and also various kinds of problems. This is of course possible by the fact that actual numerical data are produced reflecting the amount of change from pre to post treatment times.

There is reflected in the literature and in various agency settings a global pre-post approach in determining program effectiveness in therapy. This method involves an assessment of the overall mental health state of a person, quantified by one numerical score. This method may be somewhat more simple and it certainly is a quantifiable and useful method. However, finer pinpointing of problem catergories seems well worth the effort in providing information which will make program planning more effective and productive.

The evaluation system proposed here is both simple enough that staff personnel will accomplish it and also provides very meaningful information. It is recognized that some refinement and adaptation will be needed in the future. One step planned in the near future is to determine inter-rater reliability on the different items to see if the definitions are clear and discreet enough to be consistently rated by different people. Another question is whether to check several problem catergories as they exist with a client or confine ourselves to a limited number such as three maximum. Presently all significant catergories are checked. Though some refinement needs to be done with the instrument and procedure, it appears that the basic approach is most useful from the standpoint of planning services and also for reporting therapeutic effectiveness.

WEBER MENTAL HEALTH CENTER
EVALUATION SUMMARY AND TREATMENT PLAN

NAME: _____ INTAKE DATE: _____
AGE: _____ SEX: _____ REFERRAL SOURCE: _____
ETHNIC GROUP: _____ FEEDBACK REQUESTED: _____
MARITAL STATUS: _____ PHYSICIAN: _____
OCCUPATION/SCHOOL: _____ COURT: _____

(1-7) CONTACT NUMBER: _ _ _ _ _ _ _ VOLUNTARY: YES ___ NO ___
(8) PREVIOUS HISTORY: 1) ___ Yes 2) ___ No
RECORDS REQUESTED: _____

PROBLEM:

PRESENTING PROBLEM:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PROBLEM CHECKLIST: (9) PROBLEM DISTURBING TO SELF ___ OTHERS ___ BOTH ___

BEHAVIOR:
(10) ___Withdrawing
(11) ___Hyper-Active
(12) ___Suicide Attempts
(13) ___Compulsive
(14) ___Odd
(15) ___Argumentative
(16) ___Rebellious
(17) ___Impulsive
(18) ___Manipulative
(19) ___Threatening
(20) ___Assaultive
(21) ___Destructive
(22) ___Substance Abuse
(23) ___Illegal Acts
(24) ___Sexual Deviation
(25) ___Dependency
(26) ___Agreements

MOOD:
(27) ___Anxiety
(28) ___Depression
(29) ___Guilt

(30) ___Frustration
(31) ___Anger
(32) ___Apathy
(33) ___Inappropriate
(34) ___Elation
(35) ___Variable

DISTURBED PHYSIOLOGICAL FUNCTION:
(36) ___Tension
(37) ___Sleep
(38) ___Eating
(39) ___Sex
(40) ___Neurological
(41) ___Medical

MENTAL STATUS:
(42) ___Cooperation
(43) ___Communication
(44) ___Attention
(45) ___Orientation

(46) ___Relevant
(47) ___Coherent
(48) ___Delusions
(49) ___Hallucinations
(50) ___Memory
(51) ___Judgement
(52) ___Intelligence
(53) ___Fantasy
(54) ___Negative Self-Statements
(55) ___Suicide Thoughts
(56) ___Obsessive Thoughts
(57) ___Ambivalence
(58) ___Blames Others
(59) ___Motivation

SITUATIONAL:
(60) ___Family
(61) ___Living Arrangements
(62) ___Work
(63) ___Financial
(64) ___Socialization
(65) ___Legal
(66) ___Educational

COMMENTS:

_____ _____
_____ _____
_____ _____
_____ _____

PROBLEM SUMMARY:
SITUATIONAL (Specify): _____
SOCIAL/LEARNING: Self-Image ____ Disagreements ____ Specific Learned Behavior ____
PHYSIOLOGICAL: Tension ____ Sleep ____ Depression ____
MEDICAL (Specify): _____ D.S.M. _ _ _ _ _ _ _

REFERRED TO OTHER AGENCY (Specify): _____

A/26/77

TREATMENT PLAN

PROBLEM SUMMARY:

SITUATIONAL (Specify): _____

SOCIAL/LEARNING: Self-Image ____ Disagreements ____ Specific Learned Behavior ____

PHYSIOLOGICAL: Tension _____ Sleep _____ Depression _____

MEDICAL (Specify): _____

OBJECTIVES:

SHORT-TERM:

LONG-TERM:

METHOD:

MODALITY:

COUNSELING:

(10) ___Individual
(11) ___Group
(12) ___Family

CLASSES:

(13) ___Self-Image
(14) ___Assertiveness Training
(15) ___Relaxation Therapy
(16) ___Behavior Modification
(17) ___Self-Regulation
(18) ___Weight Reduction
(19) ___Disagreement Management
(20) ___Marital Relations
(21) ___Parent Training
(22) ___Family Communication
(23) ___Learning Disabilities
(24) ___Other (Specify) _____

MEDICAL:

(25) ___Chemotherapy
(26) ___Methadone Therapy
(27) ___Other (Specify) _____

SITUATIONAL MANIPULATION:

(28) ___Living Arrangements
(29) ___Socialization
(30) ___Financial
(31) ___Other (Specify) _____

OTHER:

(32) ___Specify _____

SERVICE:

(33) ___Inpatient-Local
(34) ___Inpatient-State Hospital
(35) ___Partial
(36) ___Outpatient
(37) ___Other (Specify) _____

EVALUATOR

DATE EVALUATED

ASSIGNED THERAPIST

CLIENT'S SIGNATURE

REVIEWER'S SIGNATURE AND TITLE

DATE REVIEWED

REVIEWER'S COMMENTS: _____

PLAN CHANGES: (DATE) _____